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CURRENT PREVALENCE OF COMMUNICABLE DISEASES IN THE UNITED STATES [1]

June 16–July 13, 1935

The prevalence of certain important communicable diseases, as indicated by weekly telegraphic reports from State health departments to the United States Public Health Service, is summarized in this report. The underlying statistical data are published weekly in the Public Health Reports, under the section entitled "Prevalence of Disease."

Poliomyelitis.—For the 4 weeks ended July 13, 653 cases of poliomyelitis were reported, as compared with 240 cases for the preceding 4 weeks. Exclusive of last year, when an epidemic in California and other Western States reached its peak during this period, the current incidence was the highest for this season in the 7 years for which data are available.

The current high incidence, however, is not general, but seems so far to be confined to a few States. In North Carolina, where an outbreak has been in progress, an average of about 55 cases per week has been reported for the past 6 weeks. In Virginia the number of cases has also been considerably above the seasonal expectancy. Tennessee, California, and New York reported slight increases over last year, but other States either appeared to be free from the disease or had only a normal seasonal incidence.

The accompanying table gives the number of cases reported from each State, by weeks, since May 12, 1935.

[1] From the Office of Statistical Investigations, U. S. Public Health Service. The numbers of States included for the various diseases are as follows: Typhoid fever, 48; poliomyelitis, 48; meningococcus meningitis, 48; smallpox, 48; measles, 47; diphtheria, 48; scarlet fever, 48; influenza, 44 States and New York City. The District of Columbia is counted as a State in these reports. These summaries include only the 8 important communicable diseases for which the Public Health Service receives regular weekly reports from the State health officers.

TABLE 1.—*Poliomyelitis cases reported by States in recent weeks of 1935*

Division and State	Week ended—									
	May 18	May 25	June 1	June 8	June 15	June 22	June 29	July 6	July 13	July 20
All States [1]	19	38	50	51	101	146	160	156	191	227
New England:										
Maine	0	0	1	0	0	0	0	1	0	0
New Hampshire	0	0	0	3	0	1	1	0	0	1
Vermont	0	0	0	0	0	0	0	0	0	0
Massachusetts	0	2	0	0	1	2	3	1	3	12
Rhode Island	0	0	0	0	0	0	0	1	1	2
Connecticut	0	0	0	0	0	1	1	0	2	3
Middle Atlantic:										
New York	1	2	1	1	1	12	8	11	18	21
New Jersey	0	1	2	2	1	1	3	0	4	1
Pennsylvania	0	0	0	2	0	0	3	0	0	1
East North Central:										
Ohio	0	0	0	1	1	2	1	1	0	1
Indiana	0	0	0	1	1	1	0	0	0	0
Illinois	0	0	1	1	2	0	2	2	5	2
Michigan	0	0	1	0	0	1	1	2	1	0
Wisconsin	1	1	0	0	1	1	1	1	2	1
West North Central:										
Minnesota	0	0	1	1	2	0	0	1	0	0
Iowa	1	0	1	0	0	0	0	0	0	0
Missouri	0	0	0	1	0	0	0	1	1	2
North Dakota	0	0	0	0	0	0	0	0	0	0
South Dakota	0	0	0	0	0	0	0	1	0	0
Nebraska	0	0	0	0	0	0	0	0	0	0
Kansas	0	0	0	1	0	0	0	1	0	0
South Atlantic:										
Delaware	0	0	0	0	0	0	0	0	0	1
Maryland	0	0	0	1	0	0	0	1	0	0
District of Columbia	0	0	0	0	0	0	0	0	3	1
Virginia	1	0	2	1	3	16	24	28	45	72
West Virginia	0	0	1	1	0	0	0	1	0	0
North Carolina	2	18	25	17	57	60	63	55	52	48
South Carolina	0	0	1	0	0	2	2	0	3	1
Georgia	0	3	1	0	0	0	1	0	0	1
Florida	1	0	1	1	0	0	0	2	0	0
East South Central:										
Kentucky	0	0	0	0	0	1	1	0	0	5
Tennessee	1	0	0	0	0	1	1	5	11	3
Alabama	0	1	2	1	2	0	5	2	6	3
Mississippi	0	0	1	0	1	0	0	0	1	0
West South Central:										
Arkansas	0	0	0	1	0	1	0	0	0	1
Louisiana	4	2	4	2	7	3	4	3	3	7
Oklahoma	1	1	0	0	0	0	0	1	0	0
Texas	1	0	0	3	0	5	0	2	1	1
Mountain: [1]										
Montana	0	0	0	0	0	1	1	0	0	0
Idaho	0	0	0	0	1	0	0	0	0	0
Wyoming	0	0	0	0	0	0	0	0	0	0
Colorado	0	0	0	0	0	0	0	0	0	0
New Mexico	0	0	0	0	0	1	0	0	0	0
Arizona	0	1	1	0	0	1	0	0	0	0
Utah	0	0	0	0	0	0	0	0	0	0
Pacific:										
Washington	2	0	0	0	0	0	0	0	0	0
Oregon	0	0	0	0	0	0	1	0	0	1
California	3	6	3	9	20	32	33	32	29	35

[1] Nevada excluded.

Meningococcus meningitis.—The number of cases of meningococcus meningitis dropped from 568 for the preceding 4 weeks to 392 for the 4 weeks ended July 13. The current incidence was still about three times that for the corresponding period last year and was the highest for this period since 1929.

The table shows the number of cases reported in each geographic area by weeks since May 19, with totals for a preceding 24-week period and for the corresponding period of the 2 preceding years.

TABLE 2.—*Meningococcus meningitis cases reported in each geographic area for recent weeks of 1935* [1]

Division	Cases reported for 24 weeks ended—			Week ended—								
	May 20, 1933	May 19, 1934	May 18, 1935	May 25	June 1	June 8	June 15	June 22	June 29	July 6	July 13	July 20
All divisions	1,873	1,303	3,044	152	147	161	108	132	94	78	85	65
New England	54	54	70	5	5	4	1	2	0	1	4	1
Middle Atlantic	279	181	461	24	38	35	24	48	27	14	13	15
East North Central	623	363	776	42	32	35	19	17	25	19	31	15
West North Central	259	160	389	16	12	15	19	8	5	7	7	9
South Atlantic	183	173	551	27	23	42	29	37	15	11	14	13
East South Central	149	113	301	11	10	13	3	8	9	5	4	6
West South Central	160	138	208	8	6	8	4	4	2	12	3	1
Mountain	68	52	104	4	9	1	3	0	3	1	5	2
Pacific	98	69	184	15	12	8	6	8	8	8	4	3

[1] See PUBLIC HEALTH REPORTS for June 7, May 10, Apr. 12, and July 5, 1935, for weekly data by geographic areas for the earlier part of 1935.

While the number of cases fluctuated considerably during the current period, it is evident that the disease was considerably less prevalent in all sections of the country than it was during the preceding 4-week period. However, the incidence in each section was well above that for the corresponding period in the 2 preceding years. The New England States have been the least affected by the current wave, and the increase over last year was apparently greatest in the South Atlantic and East North Central areas.

Smallpox.—The incidence of smallpox, although declining seasonally, still maintained an excess over recent years. Reported cases for the 4 weeks ended July 13, numbered 552, as compared with 204, 424, and 482 for the corresponding period in each of the 3 preceding years, regressively. The disease declined rapidly in States in the West North Central, Mountain, and Pacific regions, where it has been most prevalent, but the incidence in those regions remained considerably above that of recent years. In the South Central regions the incidence was low—the South Atlantic section reported 17 cases, 13 of which occurred in Georgia—while no cases were reported from the New England and Middle Atlantic States.

Influenza.—The influenza incidence was close to the average for recent years. For the 4 weeks ended July 13, for the country as a whole, 1,170 cases were reported. The number of cases in the North Central sections was somewhat above the expectancy for this period, but in other areas the incidence either approximated that of last year or fell slightly below.

Diphtheria.—For the current period, 1,528 cases of diphtheria were reported. The East North Central and South Atlantic regions reported slight increases over last year's figure for the same period, but in all other sections of the country the disease was less prevalent.

While the current incidence approached very closely that for the corresponding period last year (1,592), it remains the lowest in recent years.

Measles.—The number of cases of measles reported for the 4 weeks ended April 13 was 41,474, approximately 50,000 less than were reported for the preceding 4-week period. The incidence was only about 20 percent in excess of that for the corresponding period last year, but it was much higher than in preceding years. Each geographic area reported a decline, but not sufficient in the areas in which the disease has been most prevalent (North Atlantic, North Central, Mountain, and Pacific) to bring it down to the level of last year.

Typhoid fever.—The expected seasonal increase of typhoid fever was apparent in all sections of the country, but the total number of cases (1,911) was still below the figures for the corresponding period in previous years. Minnesota, with 110 cases, most of which occurred in Minneapolis, brought the incidence in the West North Central area about 40 percent above that of last year, while North Carolina (132 cases) and South Carolina (141 cases) seemed mostly responsible for an increase in the South Atlantic region. In the North Atlantic sections the incidence was about on a level with that of last year, and other areas reported appreciable decreases.

Scarlet fever.—The number of cases of scarlet fever dropped from 22,446 for the 4 weeks ended June 15 to 9,775 for the current 4 weeks. The incidence was, however, still high in relation to previous years. For this period in 1934, 1933, and 1932 the numbers of cases totaled 7,517, 6,759, and 7,538, respectively. Each geographic area reported a decline, but in all regions except the South Central the figures were well above those of last year. In the South Central sections the incidence has been the lowest in recent years; but during the current period the rate of decrease was somewhat slower than in other sections, and for the first time during the current year the number of cases in the South Central areas exceeded that for last year.

Deaths, all causes.—The death rate from all causes in large cities, as reported by the Bureau of the Census, was about normal as compared with previous years. For the 4 weeks ended July 13 the average weekly rate was 10.1 per 1,000 inhabitants (annual basis). For the preceding 4 years the average for the corresponding periods was 10.2.

ROENTGENOLOGICAL APPEARANCES IN SILICOSIS AND THE UNDERLYING PATHOLOGICAL LESIONS

A Report by a Committee Composed of Dr. H. K. Pancoast, Dr. E. P. Pendergrass, Dr. A. R. Riddell, Dr. A. J. Lanza, Dr. Wm. J. McConnell, Dr. R. R. Sayers, Dr. H. L. Sampson, and Dr. L. U. Gardner

The current use of a variety of classifications for the roentgenological appearances of silicotic lesions is making it difficult to correlate the results of a rapidly increasing number of observers. In South Africa, where silicosis is a product of a single industry and where the problem is handled almost exclusively by a bureau of the Government, the classification that has evolved is entirely adequate for their purposes; but in a highly industrialized country silicosis develops in a great variety of occupations. A diagnosis may be required of a physician in a plant, in a public health office, in a sanatorium, or in the physician's private office. Sometimes he may have had little experience in the interpretation of roentgenograms of the chest and will be forced to lean heavily on the interpretation of a roentgenologist. The legal aspects of the problem have placed grave responsibilities on the medical profession and have often been a source of embarrassment. Only the physician who has examined the subject, has obtained an occupational history of an adequate exposure to silica dust, and has before him a suitable roentgenogram of the chest should make the diagnosis of silicosis. The roentgenologist, not in possession of these facts, can merely state whether the shadows which he sees in a film are consistent with this diagnosis.

If objective terms, descriptive of the type of pathological changes, could be generally adopted, material progress would result. The clinician would not have to accept a diagnosis from the roentgenologist, general students of the disease would be able to correlate the findings of various observers, and more accurate definition of roentgenograms would be available for medico-legal purposes. Roentgenograms of the chest, which are notoriously difficult to reproduce as illustrations, could be described in word pictures capable of interpretation in the light of the personal knowledge of the observer. An error in diagnosis need not necessarily be passed on to others not in possession of the original film.

With these obstacles in mind, a committee has been at work for the past 2 years preparing a tabulation of the various lesions of silicosis together with terms that attempt to depict the character of the shadows cast on an X-ray film by these lesions. This report is submitted to invite criticism in the hope that the terms suggested, or others of a similar nature, will be generally adopted.

It should be distinctly understood that the tabulation which follows applies only to *silicosis*, that form of pneumoconiosis resulting from the inhalation of dust with a high silica (SiO_2) content.[1] Other forms, like asbestosis, are excluded from this consideration because their pathology is essentially different from that of silicosis.

The tabulation contains two columns: On the left are the roentgenological appearances and on the right are the corresponding pathological lesions. There is further subdivision to describe the appearances of (1) healthy lungs, (2) the uncomplicated silicotic lung, and (3) lung of silicosis with infection. The changes described under the first division are those compatible with a state of good health; and while they *may* be produced by the inhalation of relatively small amounts of silica dust, they are not sufficiently characteristic or advanced to substantiate a diagnosis of silicosis. Similar or identical appearances may also result from the inhalation of nonsiliceous dusts, from certain infections, from cardio-vascular disease, and from certain other rare conditions. The changes involved are for the most part confined to the lymphatics and perilymphatic connective tissues and do not affect the parenchyma of the lung. Since, by definition, silicosis is a disease characterized by nodular fibrosis in the parenchyma of the lung, these alterations, even when they may have been caused by inhaled silica, do not constitute a basis for a diagnosis of silicosis. The second group covers the discrete and conglomerate nodular fibrotic reactions of simple silicosis. The last group deals with silicosis complicated by infection. In the majority of instances the infecting organism is the tubercle bacillus, but the classification is sufficiently broad to include other types of infection. Certain criteria by which one attempts to differentiate various forms of infection will be discussed.

Roentgenological appearances	*Histological appearances*
HEALTHY LUNGS AND ADNEXA	
1. *Healthy lungs.*—As defined by the N. T. A. Committee report.	1. Essentially the normal tissues of the vascular tree, the mediastinum, the bronchi, and trachea.
2. Irregular exaggeration of the linear markings, with possibly some beading confined to the trunks.	2. Cellular connective tissue proliferation about lymphatic trunks in the walls of vessels and bonchi. Beading may be due to various causes, as blood vessels seen end on, arteriosclerosis, minute areas of fibrosis in lymphoid tissues along the trunks.

[1] Some of the nonsiliceous components of certain industrial dusts seem to modify the pathological reaction, but the character of shadows cast by these modified lesions is not sufficiently defined at the present time to include them in the tabulation. Later, when more information has accumulated, certain other terms may have to be included.

Roentgenological appearances	*Histological appearances*
HEALTHY LUNGS AND ADNEXA—continued	
3. Increased root shadow.	3. Cellular reaction in the tracheobronchial lymph nodes with extensions along afferent lymphatic trunks.

These changes come within normal variations when not accompanied by recognized organic disease.

SIMPLE SILICOSIS	
4. *Nodulation.*—Discrete shadows not exceeding 6 mm in diameter, tending to uniformity in size, density, and bilateral distribution, with well-defined borders surrounded by apparently normal lung shadow. The outer and lower lung fields characteristically show fewer nodules.	4. Circumscribed nodules of hyaline fibrosis located in the parenchyma of the lung. Occasionally some of these nodules may show microscopic foci of central necrosis.
onglomerate shadows that appear to result from a combination or consolidation of nodulation usually with associated emphysema manifested by— *a.* Localized increased transparency of the lung with loss of fine detail. *b.* Intensification of the trunk shadows by contrast. *c.* Depression of the domes with possible tendency toward individualization of the costal components of the diaphragm. *d.* Lateral view: Increase in the preaortic and retrocardiac space with exaggerated backward bowing of the spine. Widening of the spaces between the ribs may or may not be present.	5. The result of coalescence of discrete nodules; an area in which the nodules are closely packed and most of the intervening lung is replaced by more or less hyaline fibrous tissue. The lung architecture is partially obscured. No demonstrable evidence of infection. Emphysema is a compensatory dilatation of the air spaces with or without thickening of the septa.
SILICOSIS WITH INFECTION	
The characteristic appearances described under simple silicosis are modified by infection as follows:	
6. Localized discrete densities and/or string-like shadows accompanying those of simple silicosis described above.	6. Strands of fibrous tissue, often along trunks and septa, with or without areas of calcification; indicative of "healed" infection.

Roentgenological appearances	*Histological appearances*
SILICOSIS WITH INFECTION—continued	
7. *Mottling.*—Shadows varying in size with ill-defined borders and lacking uniformity in density and distribution, accompanying simple silicosis.	7. (*a*) Areas of broncho-pneumonia with or without caseation, i. e., acute infection. (*b*) Lobular areas of proliferative reaction with or without caseation, i. e., chronic infection.
8. *Soft nodulation.*—The nodular shadows described under simple silicosis, 4, have now assumed fuzzy borders and/or irregularities in distribution. This change may or may not accompany the simple mottling of 7.	8. Perinodular cellular reaction either exudative or proliferative in character.
9. *Massive shadows* of homogeneous density not of pleural origin symmetrically or asymmetrically distributed.	9. Extensive areas of fibrosis probably due to organized pneumonia of tuberculous or nontuberculous origin superimposed upon a coexistent silicotic process. Outlines of normal structures may be partially destroyed.

COMMENT

For the first group of appearances we have adopted the nomenclature of the National Tuberculosis Association Committee and described the lungs as *healthy* rather than *normal*, as a perfectly normal adult human being is a great rarity. For a description of the roentgenological appearance of the healthy chest the reader should consult a paper by Pancoast, Baetjer, and Dunham in the American Review of Tuberculosis for 1927, vol. 15, pp. 429–471.

As already mentioned under 2, *Irregular exaggeration of the linear markings, with possibly some beading*, belongs in the healthy chest group even when found in persons with a history of considerable exposure to silica, for such changes are nonspecific in character and they do not involve the parenchyma of the lung. Silicosis as a clinical disease begins only when the lung proper is affected. Likewise, under 3, *Increased root shadow* may be of nonspecific origin and hence is not diagnostic. In the *early* stages of silicosis the mediastinal shadow may be widened, owing to the enlargement of the tracheobronchial lymph nodes from accumulated dust and cellular reaction to it; later, when specific fibrosis develops, the tissues generally contract and the nodes decrease in size. The changes described under 2 and 3 may be caused by many forms of irritation; if they are due to silica they are identifiable only by microscopic examination. They do not apparently interfere with respiratory function, and they are not of diagnostic significance.

The second group of changes is limited to *simple silicosis* uncomplicated by demonstrable signs of infection. This condition is characterized by the presence of small, discrete nodules of fibrous tissue disseminated throughout the functional parts of both lungs. The lesions and the shadows cast by them tend to be spherical, hard, sharply defined, and vary in size from 2 to 6 mm. While the distribution is usually uniform throughout both lungs, the extreme apices and the outer portion of the bases are frequently uninvolved. In less advanced cases the nodules remain discrete and separated by air-containing tissue. Irvine has aptly compared the shadows observed in the roentgenogram of the silicotic lung to those cast by a tree. In the earliest stages, when the reaction to silica is confined to the perilymphatic connective tissues, producing an accentuation of the linear markings, the shadow is that of a leafless tree. As small nodules begin to appear in the parenchyma of the lung, the tree begins to bud and the shadow of its branches is less clearly defined. When the tree is in full leaf, the stage of advanced nodulation, the shadow of the branches is completely obscured. Previous classifications have been concerned largely with the degree of nodulation as determined by the size and number of the nodules in the lung. We will not attempt to deal with this problem here, but choose to leave the "stage" of the silicosis to the internist, who has physical findings as well as a roentgenogram at his command.

Number 5 deals with the *conglomerate shadows* of simple silicosis, which appear to develop from a combination or consolidation of discrete nodules. The resultant lesion and the shadow that it casts are often difficult to distinguish from the *massive shadows* of silicosis with infection, 9. It is generally assumed that conglomeration results from accidental overlapping and fusion of discrete nodules when they become very numerous; but since conglomeration is usually a localized affair and does not occur in the same position of the lung of every individual, it is logical to enquire why the nodules happen to fuse in one portion of the lung and not in others. Microscopic examination of the tissues from such areas reveals no evidence of active infection. The nodules seem to be much closer together than in other portions of the lung, they are less uniform in size, and they are usually embedded in a matrix of diffuse fibrous tissue having the same characteristic hyaline appearance as that forming the nodules themselves. It seems probable that conglomeration may have occurred because the portion of the lung in question was previously damaged by a localized inflammatory process occurring before or during the early period of dust exposure. Because the tissue was injured, more dust would tend to accumulate in the area, the nodules would develop irregularly and would frequently be very close together. The silica lodging in preexisting granulation or scar tissue would exert its characteristic

effect, and a diffuse hyalinization would result. This explanation for conglomerate reaction is at present hypothetical; proof will come from long continued serial roentgenographic studies of groups of persons exposed to silica dust and from the chance autopsy that may be obtainable. To differentiate *conglomerate shadows* from the *massive shadows* of infection, 9, reliance must be placed upon the absence of change in size and character of the shadows in serial films taken over an extended period of time and upon the clinical findings in the case.

Emphysema is usually associated with far advanced silicosis and it is particularly liable to complicate conglomerate nodulation. It occurs in the immediate vicinity of the conglomeration as a result of the distortion produced by contracting scar tissue; there is also a generalized "compensatory" emphysema found along the borders of the lung, particularly at the bases. The latter type is also common in far-advanced generalized nodulation.

In the last group, *silicosis with infection*, are included all cases with detectable evidence of infection whether active or inactive. In this respect we depart from the South African procedure, which includes here only active infection. The difficulty of determining activity, particularly in the silicotic subject, is our chief reason for this arrangement.

Number 6 covers foci of healed infection. Identification of such changes depends upon the same criteria that are generally employed in otherwise normal individuals. In the silicotic subject the shadows usually occur upon a background of generalized nodulation, although in some cases there may be a distinct tendency toward excessive nodulation in the immediate vicinity of the scars left by the infection. Where the exposure to dust has been limited, the major evidence of nodulation may occur about the foci of healed infection with much less reaction in the remainder of the lung. The string-like shadows of healed fibroid tuberculosis are not difficult to interpret if they occur in the classical location, i. e., in the upper third of the lung. In the lower lung they present a problem whose solution depends largely upon the experience of the roentgenologist.

The term *mottling*, 7, we have reserved to describe the shadows of infectious lesions in contradistinction to *nodulation*, which is restricted to those of the silicotic dust nodule. It is essential that this distinction be appreciated and recorded in the terminology. In tuberculosis, mottling is due to bronchogenic or aspiration foci of disease which exhibit a characteristic clustered arrangement. The lesions may be exudative (acute) or productive (chronic) in type; the difference will be registered on the roentgenogram by a mottling which is fluffy and ill-defined, or hard and sharply defined as the case may be. The distribution of the mottled foci, together with the presence of large foci of older disease interpreted as tuberculosis, and clinical and

laboratory findings establish the character of the infection. Mottling due to chronic infection that has developed previous to or simultaneous with the relatively early periods of dust exposure may exhibit little or no effect from the inhaled silica for many years. In nontuberculous broncho-pneumonias the large chronic foci are absent, and the disseminate mottling may involve different parts of one lung or of both lungs. In many instances the nature of the infection must be established by serial examinations over considerable periods of time and by careful correlation with clinical and bacteriological findings.

Soft nodulation, 8, is a term that has been coined to describe a rather uncommon combination of silicosis with infection, usually tuberculous. The ordinary hard, sharply defined nodular shadows of simple silicosis, under these circumstances, appear to have enlarged and lost definition. Their borders are now fuzzy and blend imperceptibly with the surrounding lung structure. Such lesions generally occur in association with localized conglomerate shadows in the apex or other portions of the lung. Histologically the infection appears to have localized in and about preexisting silicotic nodules so that each is surrounded by a zone of exudative or productive cellular reaction.

Massive shadows of homogenous density, 9, are cast by the areas of combined silicosis and infection, usually chronic in nature. The two processes appear to have developed simultaneously and unusual amounts of dust accumulate in the diseased area. Generalized nodulation usually occurs throughout the remainder of the lungs. Pleural densities can be differentiated in stereoroentgenograms, and by overexposure it often becomes possible to penetrate the extremely dense intrapulmonary areas and analyze their internal structure. Not infrequently cavities may be visualized that were completely overlooked with the usual technique. When due to tuberculosis, such lesions are often bilaterally symmetrical. If the process extends to the pleural surface, a tuberculous etiology is postulated, while other infections are more often deep-seated.

Histological examination of such lesions shows conglomerations of simple nodules embedded in masses of more or less perfectly organized granulation tissue. Often the fibrous tissue has undergone the same peculiar hyalinization that characterizes the interior of the silicotic nodule. Usually the outlines of the original lung architecture are completely destroyed. Manifestations of infection depend upon the nature of the process. If tuberculous, there will be foci of caseation and possibly small cavities. Calcification is not infrequent. If the process is inactive the presence of fibrous tubercles which do not exhibit the hyalinization of silicosis may be present. The occurrence of giant cells is helpful. A partially organized nontuberculous pneumonia usually contains foci of acute exudation of variable size. Clinically such unresolved pneumonias frequently exhibit periods of

exacerbation followed by regression. They may be due to a great variety of organisms, including the Friedlander group and oral anaerobes. Where all manifestations of activity have disappeared, the lesion is probably best classified as a conglomerate shadow of simple silicosis, 5.

The differentiation between these *massive shadows* of infectious origin and the conglomerate shadows of far-advanced simple silicosis is difficult and not always possible. Repeated reexamination of the patient for evidence of change in the roentgenographic appearance of the lesion, penetration of the massive areas by overexposure to analyze its internal structure, the clinical behavior of the patient, and repeated bacteriological examination of the sputum may all be necessary to determine whether an active infection is present.

It is hoped that the suggested terminology will receive a practical test. If others find it usable, the advantage of standard descriptive terms should outweigh the conservatism of those who are already using classifications of their own.

DEDICATION AND OPENING OF THE LEXINGTON NARCOTIC FARM

By W. L. Treadway, *Assistant Surgeon General, United States Public Health Service*

The first United States Narcotic Farm, at Lexington, Ky., was formally dedicated and opened by the Surgeon General on the afternoon of May 25, 1935. It was opened for inspection by the general public on the day of dedication and on the following Sunday, Monday, and Tuesday, after which it was closed to visits by the general public. During the 4 days in which it was opened to general inspection, 17,241 persons visited the institution, many of whom came long distances by motor from adjoining States. Three thousand four hundred and eighty visitors attended the dedication and opening exercises.

Admissions were accepted on and after May 29, 1935. Arrangements were made for the transfer of some 300 addict prisioners from the Federal prison system; to accept cases placed on probation by courts having jurisdiction, one condition of such probation being that the probationers voluntarily submit themselves to confinement and treatment in a narcotic farm; and to accept a limited number of persons voluntarily seeking treatment. On June 30, 1935, there were under care at the Lexington Narcotic Farm a total of 280 inmates.

The institution at Lexington, Ky., is for men only, 1,000 beds being provided, although it is contemplated that facilities will be developed for women addicts in the near future, as an adjunct to those facilities already provided for men.

The institution at Fort Worth, Tex., is in process of being developed. The preliminary plans have been approved, and it is an-

ticipated that the contract for the necessary buildings will be accepted some time during the present summer.

The institution at Lexington is designed primarily for the care of the more intractable type of person, largely the prisoner group. For that reason, the custodial features have been emphasized. The institution at Forth Worth will be more open in character, being designed as a cottage type, and the custodial features will be less emphasized than those at Lexington. Experiences have indicated that there are certain groups of addicts who require that greater emphasis be placed on custodial care, while others may be benefited by a more liberal policy. The institution at Forth Worth, therefore, will be supplemental to that at Lexington.

The problem of institutional treatment for drug addiction, however, must take into account not only the precipitating and underlying causes of addiction, but the diverse motives or underlying reasons for seeking treatment, the incidence of intercurrent diseases and defects in such a group, the great differences in the types of personalities involved, and the need for protecting the institution community against the weaknesses and cupidity of its component individuals. The important precipitating, or immediate, causes of addiction are related to the previous uses of such drugs in medical treatment, to self-treatment for the relief of pain, to recourse to drugs during emotional stress, to the influence of and association with others who are habituated to their uses, to overcome drunkenness, and to indulgence for the sake of experience, curiosity, a thrill, or bravado.

The more important predisposing or underlying causes of addiction are related to the inherent constitutional make-up of the individual. The so-called nervously unstable person is more prone to embrace the habitual use of narcotic drugs than one with a stable constitution. Experience with persons addicted to the use of habit-forming drugs indicates that they had many emotional difficulties and inner conflicts long before they became addicted to the use of such drugs. Hence the fundamental factors in the treatment and rehabilitation of such persons are a definite challenge to psychobiology and necessitate an appreciation of the mental hygiene factors involved.

A situation wherein an individual, through long use of opium or its derivatives, may safely take large doses of his drug that would be fatal to one unaccustomed, has intrigued the interest of many observers. It has been explained on the grounds that the oxidation of morphine within the body produces a toxic byproduct that is neutralized by an additional intake of morphine and, unless so neutralized, gives rise to abstinence symptoms. This theory, together with that of a supposed development of active immunity from the use of such drugs is of historical interest only. Other hypotheses deal with the fate of morphine in the human body. These hinge upon the theory that the

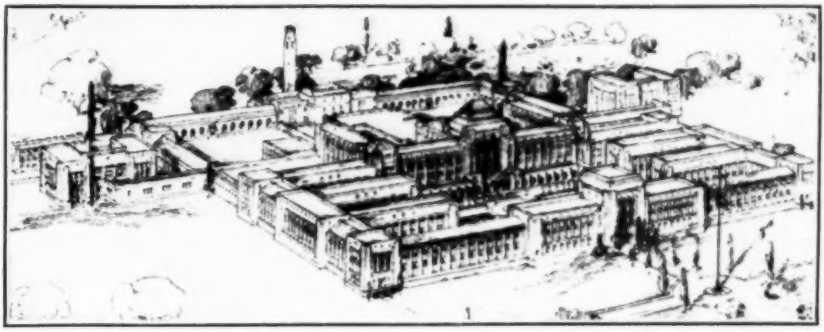
rate of destruction is increased through habituation; that muscle tissue, acting as a buffer, develops the power to store morphine and to release it so gradually as not to affect the nervous system fatally; that body cells, particularly nerve cells, are rendered less sensitive through continued use of the drug; and that the glycerophosphoric or choline-lecithin portion of the cell molecules is replaced by the alkaloid. A great deal of work is required, however, before these hypotheses can be established on firm footings.

Other theories have been advanced to explain the phenomena of tolerance based upon physiological interpretations. Thus, there is the one which considers a simultaneous stimulation and depression of different parts of the nervous system, tolerance being established through accumulation of higher levels of stimulation that outlast and ultimately replace the more fleeting depressant effects. In the other, which concerns an imbalance in the autonomic and endocrine systems, conflicting opinions arise, and they appear to be confused with the stimulation-depression theory already mentioned. A conclusion that tolerance is no more than a question of physiological balance does not simplify an understanding of its mechanism or how it operates.

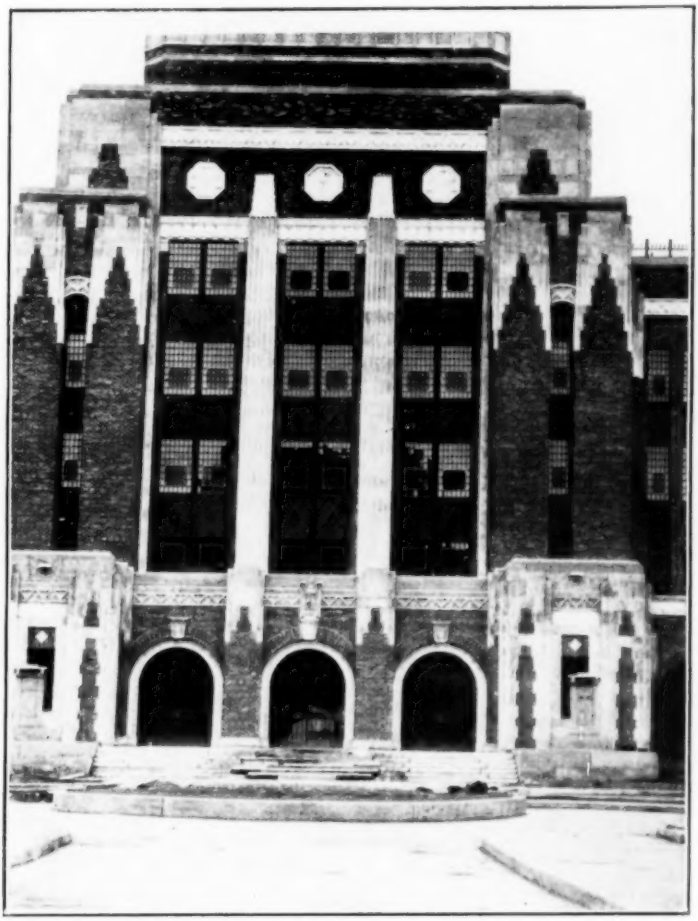
Specific treatment for chronic opium poisoning hinges upon a better understanding of the mechanism of drug tolerance and of abstinence symptoms. The conclusions of one group of observers, who seemingly had established some basic principles, have been refuted by others, so that the situation remains confused. Much investigative work has been accomplished, however, that may serve as guideposts for future inquiries, but a great deal of it has been pocketed in blind trails that lead nowhere.

The dedication and opening of the institution at Lexington, Ky., represents a change in the policy of the United States toward the so-called drug-addiction problem. No person will be eligible for treatment or confinement in the institution unless he is an addict as defined in the law authorizing these narcotic farms, and then only if he complies with the regulations governing admissions.

The inception of the institution at Lexington is an expression on the part of the United States Government that restrictive laws governing commerce in narcotics are not the only measures to be applied as a possible solution of the medico-social problem of drug addiction. The presence in American communities of persons who are addicted to the use of narcotic drugs constitutes an ultimate market for smuggled or contraband drugs and tends to menace the legal supply of such drugs originally destined for medical or scientific purposes. Public policies, therefore, which have for their object the regulation and control of the production and distribution of narcotic drugs are proportionately as effective as those which undertake to control, segregate, or cure the drug addict population of a community.

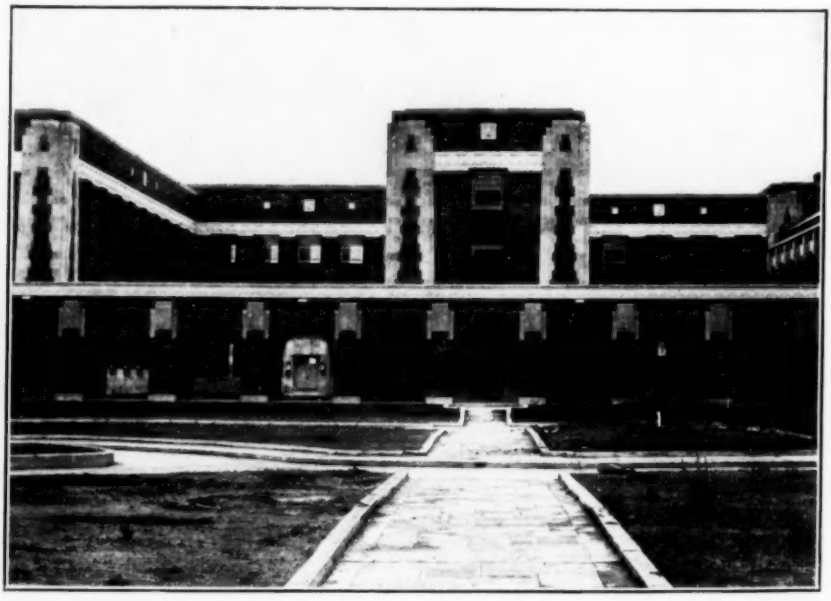


ARCHITECT'S DRAWING OF THE LEXINGTON NARCOTIC FARM, SHOWING PLAN OF BUILDINGS.



VIEW OF CENTER AND MAIN ENTRANCE OF HOSPITAL BUILDING FROM INSIDE QUADRANGLE.

MAIN ENTRANCE OF ADMINISTRATION BUILDING AS SEEN FROM QUADRANGLE.



VIEW OF DOMICILIARY WINGS, SHOWING PART OF QUADRANGLE.

The isolation and segregation of drug addicts with the object of medical treatment appears desirable and necessary; for their presence and contact with others in American communities are a potential danger and a causative factor in the production of further addiction, it being estimated that more than half of the present-day addiction is attributable to contact with other addicts.

The significance of this legislation in relation to Federal offenders may be better appreciated when it is realized that repeated prison sentences have been imposed more often upon drug addicts than on any other type of adult prisoner. The situation respecting repeated prison sentences has challenged the usefulness of handling drug addicts through prison sentence alone. An appraisal of this new policy respecting the establishment of the narcotic farms may be best made through study and investigation of the problem of drug addiction as it affects the population as a whole. Such studies have shown that addiction to habit-forming drugs is widespread; that all classes and groups of the general population are affected in one way or another; that the geographical distribution of these people corresponds relatively to the geographical distribution and density of the general population; that occupation, age period of life, nativity, sex, color, marital or educational status are not exempting factors; for drug addiction appears to be through and on the people.

Heretofore, so far as public policies are concerned, drug addiction has been regarded almost solely as a penal and correctional problem, somewhat like that of the insane of an earlier day. In the establishment of an institution such as that at Lexington, it must be appreciated that any betterment in the social, moral, economic, or commercial conduct of a self-governing people springs not from the mind of any one person, but from the congregate opinions and wishes of generations in community groups. Notwithstanding the sudden emergence of the so-called "reform movements", they are always based upon a framework that is deeply rooted in a background of tradition and community practice.

The place the narcotic farms occupy in the scheme of our social order has behind it a continuous evolutionary growth of more than three centuries. During that period, society has endeavored to set up coordinate public policies directed toward the solution of community problems and those of individuals who could not meet adversity and conform with the ever changing but liberal standards in human relationships. As American communities grew older and populations increased, as civilization and human relationship became more complex and exacting, and as isolation gave way to more intimate contacts and uniformity in outlook, there has been no escape from the constant increase in the number of those who, for various reasons, became social problems or charges upon the general public.

The object of the Lexington, Ky., farm is to rehabilitate, restore to health, and train to be self-supporting and self-reliant those who are admitted thereto. In addition, the control, management, and discipline are to be maintained for the safekeeping of the individual and the protection of American communities. Shops are being established to afford occupation, vocational training, and education. Experiments are to be carried on to determine the best methods of treatment and research in this field and the results are to be disseminated to the medical profession and the general public. In short, the functions of the institution will assume the character of a treatment and research center and of an educational, industrial, vocational, and rehabilitation center, with certain custodial features superimposed.

The fundamental background for establishing the narcotic farms represents more than the mere housing or domiciliary care of drug addicts or their individual treatment. These institutions must, because of the functions which they are expected to perform, be represented as medical centers, with all those diversified facilities which the broad activities and interests of modern medical science and the treatment of the physically and mentally sick entail. The problem of the treatment of drug addiction in its present stage involves a chemicopharmacologic, biochemical, psychobiologic, and medical approach. These institutions represent even more than individual services for those admitted; for in their conception they are an aspect of further specialization in the evolution of public policies that aim toward a partial solution of a particular problem confronting society.

These facilities, established for the confinement and treatment of persons addicted to habit-forming drugs, represent a form of specialization bearing a direct relationship to policies of law enforcement and the protection of American communities; to special problems in penal and correctional procedure; to safeguarding the uses of narcotic drugs in medical practice; to research and the quest for more accurate and fundamental knowledge concerning the nature of drug addiction and related phenomena; and to those instinctive demands ever present in the American people that the sick and afflicted shall be set in the way of strength and hope.

PUBLIC HEALTH SERVICE PUBLICATIONS

A List of Publications Issued During the Period January–June 1935

There is printed herewith a list of publications of the United States Public Health Service issued during the period January–June 1935.

The most important articles that appear each week in the PUBLIC HEALTH REPORTS are reprinted in pamphlet form, making possible a

wider and more economical distribution of information that is of especial value and interest to public health workers and the general public.

All of the publications listed below except those marked with an asterisk (*) are available for free distribution and as long as the supply lasts may be obtained by addressing the Surgeon General, United States Public Health Service, Washington, D. C. Those publications marked with an asterisk are not available for free distribution but, unless stated to be "out of print", may be purchased from the Superintendent of Documents, Government Printing Office, Washington, D. C., *at the prices noted.* (No remittances should be sent to the Public Health Service.)

Periodicals

Public Health Reports (weekly), January–June, vol. 50, nos. 1–26, pages 1 to 890.

Venereal Disease Information (monthly), January–June, vol. 16, nos. 1–6, pages 1 to 222.

Reprints from the Public Health Reports

1665. Effects of the inhalation of asbestos dust on the lungs of asbestos workers. By A. J. Lanza, William J. McConnell, and J. William Fehnel. January 4, 1935. 12 pages.

1666. Milk-sanitation ratings of cities. Cities for which milk-sanitation ratings of 90 percent or more were reported by the State milk-sanitation authorities during the period January 1, 1933, to December 31, 1934. February 1, 1935. 4 pages.

1667. Biological products. Establishments licensed for the propagation and sale of viruses, serums, toxins, and analogous products. February 1, 1935. 6 pages.

1668. Selected papers on the medical services in the Federal prison system, with special reference to psychiatric problems. Presented at the conference held at Springfield, Mo., September 13–15, 1934. The role, organization, and function of psychiatric service in a correctional institution. By R. P. Hagerman, Wilson K. Dyer, and C. C. Limburg. November 9, 1934. The social viewpoint of psychiatric service in a correctional institution. By Amy N. Stannard. November 9, 1934. The personality factor in prison discipline. By F. G. Zerbst and D. E. Singleton. November 16, 1934. Problem neuroses and their management in a correctional institution. By M. J. Pescor. November 16, 1934. The constitutional psychopath as the warden's problem. By H. C. Hill. November 30, 1934. Psychiatric aspects of job placement. By J. G. Wilson. December 21, 1934. The educator's viewpoint of psychiatric service in a penal institution. By R. A. McGee. January 4, 1935. The administrator's viewpoint of psychiatric services in a correctional institution. By Joseph W. Sanford. January 18, 1935. The place of psychiatry in a coordinated correctional program. By F. Lovell Bixby. January 25, 1935. Principles of sanitation and hygiene for a correctional institution. By M. R. King. February 8, 1935. 46 pages.

1669. The effects of exposure to dust in two Georgia talc mills and mines. By Waldemar C. Dreessen and J. M. Dalla Valle. February 1, 1935. 13 pages.

1670. Endamoeba histolytica in washings from the hands and finger nails of infected persons. By Bertha Kaplan Spector, John W. Foster, and Nelson G. Glover. February 8, 1935. 2 pages.

1671. The family survey as a method of studying rural health problems. Brunswick-Greensville health administration studies, no. 3. By Elliott H. Pennell. February 15, 1935. 14 pages.

1672. Public Health Service publications. A list of publications issued during the period July–December 1934. February 15, 1935. 3 pages.

1673. A general view of the causes of illness and death at specific ages. Based on records for 9,000 families in 18 States visited periodically for 12 months, 1928–31. By Selwyn D. Collins. February 22, 1935. 19 pages.

1674. A comparative study of streptococcal immunity, produced in rabbits by heat-killed cultures, by active bacteriophage, and by inactivated bacteriophage. By Alice C. Evans. February 8, 1935. 17 pages.

1675. State and insular health authorities, 1934. Directory, with data as to appropriations and publications. March 1, 1935. 17 pages.

1676. The occurrence of infestations with E. histolytica associated with waterborne epidemic diseases. By A. V. Hardy and Bertha Kaplan Spector. March 8, 1935. 12 pages.

1677. Variations in physique and growth of children in different geographic regions of the United States. Physical measurement studies, no. 2. By Carroll E. Palmer and Selwyn D. Collins. March 8, 1935. 13 pages.

1678. Mottled enamel in Texas. By H. Trendley Dean, R. M. Dixon, and Chester Cohen. March 29, 1935. 18 pages; 2 plates.

1679. Public health nursing in a bi-county health department. Brunswick-Greensville health administration studies, no. 4. Prepared by Pearl McIver. April 5, 1935. 12 pages.

1680. Studies of sewage purification. I. Apparatus for the determination of dissolved oxygen in sludge-sewage mixtures. By E. J. Theriault and Paul D. McNamee. April 5, 1935. 10 pages.

1681. Age incidence of illness and death considered in broad disease groups. Based on records for 9,000 families in 18 States visited periodically for 12 months, 1928–31. By Selwyn D. Collins. April 12, 1935. 19 pages.

1682. Sickness among male industrial employees during the final quarter of 1934 and the entire year. By Dean K. Brundage. April 26, 1935. 3 pages.

1683. Mortality in certain States during 1934, with comparative data for recent years. April 26, 1935. 10 pages.

1684. Relation of sickness to income and income change in 10 surveyed communities. Health and depression studies no. 1: Method of study and general results for each locality. By G. St. J. Perrott and Selwyn D. Collins. May 3, 1935. 28 pages.

1685. City health officers, 1934. Directory of those in cities of 10,000 or more population. May 10, 1935. 17 pages.

1686. Studies of sewage purification. II. A zooglea-forming bacterium isolated from activated sludge. By C. T. Butterfield. May 17, 1935. 13 pages; 4 plates.

1687. A communicable disease meter. A device for recording and comparing the current incidence of communicable diseases. By Robert Olesen. May 24, 1935. 10 pages.

1688. Prevention of intranasally-inoculated poliomyelitis of monkeys by instillation of alum into the nostrils. By Charles Armstrong and W. T. Harrison. May 31, 1935. 6 pages.
1689. Protection of mice against meningococcus infection by polyvalent antimeningococcic serum. By Sara E. Branham. June 7, 1935. 10 pages.
1690. The irritants in adhesive plaster. By Louis Schwartz and Samuel M. Peck. June 14, 1935. 9 pages.
1691. Benign lymphocytic choriomeningitis (acute aseptic meningitis). A new disease entity. By Charles Armstrong and Paul F. Dickens. June 21, 1935. 12 pages.
1692. Leprosy. The effect of a vitamin B_1 deficient diet on the incubation period of rat leprosy. By L. F. Badger and W. H. Sebrell. June 28, 1935. 9 pages.

Supplements to the Public Health Reports

113. Dilaudid (dihydromorphinone). A review of the literature and a study of its addictive properties. By M. R. King, C. K. Himmelsbach, and B. S. Sanders. 1935. 38 pages.
114. Information regarding quarantine and immigration for ship surgeons. 1935. 34 pages.

Reprints from Venereal Disease Information

49. What treatment in early syphilis accomplishes. Cooperative clinical studies in the treatment of syphilis. By John H. Stokes, Lida J. Usilton, Harold N. Cole, Joseph Earle Moore, Paul A. O'Leary, Udo J. Wile, Thomas Parran, Jr., and John McMullen. Vol. 15, no. 11. 24 pages.
50. The value of instructing the syphilis patient. By M. J. Exner. Vol. 16, no. 3. 6 pages.
51. Trend of syphilis and gonorrhea in the United States. By Lida J. Usilton. Vol. 16, no. 5. 18 pages.
52. The evaluation of serodiagnostic tests for syphilis in the United States. By H. S. Cumming, H. H. Hazen, Arthur H. Sanford, F. E. Senear, Walter M. Simpson, and R. A. Vonderlehr. Vol. 16, no. 6. 14 pages.

Public Health Bulletins

214. Report on the St. Louis outbreak of encephalitis. January 1935. 117 pages.
215. Skin hazards in American industry. Dermatitis in the rubber industry. By Louis Schwartz. Dermatitis in oil refining. By Louis Schwartz. Dermatitis in synthetic dye manufacturing. By Louis Schwartz. Dermatitis in candy making. By Louis Schwartz. Dermatitis among silk throwsters. By Louis Schwartz and Louis Tulipan. Dermatitis in the manufacture of linseed oil. By Louis Schwartz. Dermatitis due to perfume. By Louis Schwartz. Dermatitis due to pyrethrum contained in an insecticide. By Louis Schwartz. October 1934. 54 pages; 17 plates.
216. The potential problems of industrial hygiene in a typical industrial area in the United States. By J. J. Bloomfield, W. Scott Johnson, and R. R. Sayers. December 1934. 35 pages.
219. A survey of tuberculosis in Louisiana. By L. L. Lumsden. April 1935. 76 pages.

National Institute of Health Bulletins

163. Key-catalogue of parasites reported for carnivora (cats, dogs, bears, etc.), with their possible public health importance. By C. W. Stiles and Clara Edith Baker. December 1934. 310 pages.

164. Experimental studies on cancer. I. The influence of the parenteral administration of certain sugars on the pH of malignant tumors. By Carl Voegtlin, R. H. Fitch, Herbert Kahler, J. M. Johnson, and J. W. Thompson. II. The estimation of the hydrogen ion concentration of tissues in living animals by means of the capillary glass electrode. By Carl Voegtlin, Herbert Kahler, and R. H. Fitch. III. The influence of hydrogen ion concentration upon the reversal of proteolysis in oxygenated extracts of normal and neoplastic tissues. By Mary E. Maver, J. M. Johnson, and Carl Voegtlin. IV. A comparison of the growth of the Jensen rat sarcoma in subcutaneous and intramuscular transplants. By W. R. Earle and Carl Voegtlin. January 1935. 58 pages; 4 plates.

Miscellaneous Publications

10. Regulations for the sale of viruses, serums, toxins, and analogous products in the District of Columbia and in interstate traffic. Approved February 25, 1935, to supersede regulations issued March 13, 1934, and amendments thereto. 1935. 11 pages.

11. Official list of commissioned and other officers of the United States Public Health Service. Also a list of all stations of the Service. January 1, 1935. 61 pages.

Unnumbered Publications

Index to Public Health Reports, vol. 49, part 2 (July–December 1934). 1935 23 pages.

*National Negro Health Week program. This pamphlet is published annually, usually about the middle of March, for community leaders in an effort to suggest ways and means by which interested individuals and organizations may be organized for a concerted and effective attack upon the community's disease problems. Twenty-first annual observance. March 31 to April 7, 1935. 8 pages. Out of print.

*National Negro Health Week leaflet. 1935. 2 pages. Out of print.

*National Negro Health Week poster. 1935. Out of print.

DEATHS DURING WEEK ENDED JULY 13, 1935

[From the Weekly Health Index, issued by the Bureau of the Census, Department of Commerce]

	Week ended July 13, 1935	Corresponding week, 1934
Data from 86 large cities of the United States:		
Total deaths	7,679	7,163
Deaths per 1,000 population, annual basis	10.7	10.0
Deaths under 1 year of age	542	556
Deaths under 1 year of age per 1,000 estimated live births	50	51
Deaths per 1,000 population, annual basis, first 28 weeks of year	12.1	12.0
Data from industrial insurance companies:		
Policies in force	67,930,187	67,711,737
Number of death claims	12,499	12,966
Death claims per 1,000 policies in force, annual rate	9.6	10.0
Death claims per 1,000 policies, first 28 weeks of year, annual rate	10.3	10.5

PREVALENCE OF DISEASE

No health department, State or local, can effectively prevent or control disease without knowledge of when, where, and under what conditions cases are occurring

UNITED STATES

CURRENT WEEKLY STATE REPORTS

These reports are preliminary, and the figures are subject to change when later returns are received by the State health officers

Reports for Weeks Ended July 20, 1935, and July 21, 1934

Cases of certain communicable diseases reported by telegraph by State health officers for weeks ended July 20, 1935, and July 21, 1934

Division and State	Diphtheria		Influenza		Measles		Meningococcus meningitis	
	Week ended July 20, 1935	Week ended July 21, 1934	Week ended July 20, 1935	Week ended July 21, 1934	Week ended July 20, 1935	Week ended July 21, 1934	Week ended July 20, 1935	Week ended July 21, 1934
New England States:								
Maine	----	1	----	----	49	1	0	0
New Hampshire	1	----	----	----	1	69	0	0
Vermont	----	----	----	----	44	7	0	0
Massachusetts	5	8	----	----	98	126	1	5
Rhode Island	----	----	----	----	76	16	0	0
Connecticut	7	2	1	----	70	44	0	0
Middle Atlantic States:								
New York	16	16	----	[1] 3	925	254	8	3
New Jersey	5	10	----	----	309	484	0	3
Pennsylvania	28	28	----	----	553	569	7	2
East North Central States:								
Ohio	13	5	3	1	181	173	2	1
Indiana	7	13	13	10	20	48	1	0
Illinois	28	17	8	18	209	357	8	8
Michigan	7	11	----	----	619	77	4	0
Wisconsin	3	7	19	14	581	476	0	0
West North Central States:								
Minnesota	6	3	----	1	37	19	0	0
Iowa	12	6	----	----	18	40	3	0
Missouri [2]	27	16	17	6	35	36	4	2
North Dakota	----	10	----	----	13	73	0	0
South Dakota	2	1	----	----	8	15	0	0
Nebraska	5	2	----	----	11	2	0	0
Kansas	[3]	3	8	1	52	25	2	2
South Atlantic States:								
Delaware	1	----	----	----	12	2	1	0
Maryland [2] [4]	3	7	2	2	33	34	2	0
District of Columbia [4]	10	3	1	2	5	5	2	0
Virginia	8	17	----	----	37	211	2	1
West Virginia	9	9	13	3	17	68	2	0
North Carolina [2]	6	9	----	4	9	90	2	0
South Carolina [2]	4	----	58	44	1	22	1	0
Georgia [2]	17	3	----	----	----	----	0	0
Florida [2]	6	9	----	----	3	12	1	0

See footnotes at end of table.

Cases of certain communicable diseases reported by telegraph by State health officers for weeks ended July 20, 1935, and July 21, 1934—Continued

Division and State	Diphtheria		Influenza		Measles		Meningococcus meningitis	
	Week ended July 20, 1935	Week ended July 21, 1934	Week ended July 20, 1935	Week ended July 21, 1934	Week ended July 20, 1935	Week ended July 21, 1934	Week ended July 20, 1935	Week ended July 21, 1934
East South Central States:								
Kentucky	5	3	----	31	50	75	2	1
Tennessee	5	5	5	8	19	68	3	0
Alabama [3]	19	21	7	4	17	57	1	1
Mississippi [3]	12	3	----	----	----	----	0	2
West South Central States:								
Arkansas	3	----	3	----	4	----	0	0
Louisiana [3]	11	11	13	3	15	15	0	0
Oklahoma [3]	4	2	20	13	7	4	0	1
Texas [3]	23	41	11	57	15	176	1	1
Mountain States:								
Montana [4]	1	1	----	----	49	4	1	0
Idaho	----	1	----	----	3	2	0	0
Wyoming [4]	1	----	----	----	14	55	0	0
Colorado	9	8	----	----	32	74	1	1
New Mexico	1	1	3	----	3	39	0	0
Arizona	----	----	----	----	----	2	0	0
Utah [3]	----	----	----	----	5	2	0	0
Pacific States:								
Washington	1	----	----	----	75	36	0	1
Oregon [4]	2	----	3	8	53	14	1	0
California	34	29	12	16	294	140	2	3
Total	372	342	220	249	4,681	4,118	65	38
First 29 weeks of year	16,615	18,877	103,000	47,263	687,538	660,952	3,860	1,473

Division and State	Poliomyelitis		Scarlet fever		Smallpox		Typhoid fever	
	Week ended July 20, 1935	Week ended July 21, 1934	Week ended July 20, 1935	Week ended July 21, 1934	Week ended July 20, 1935	Week ended July 21, 1934	Week ended July 20, 1935	Week ended July 21, 1934
New England States:								
Maine	0	0	4	6	0	0	4	6
New Hampshire	1	0	0	1	0	0	1	0
Vermont	0	0	7	6	0	0	0	0
Massachusetts	12	5	53	63	0	0	2	4
Rhode Island	2	0	7	3	0	0	0	0
Connecticut	3	0	6	7	0	0	2	0
Middle Atlantic States:								
New York	21	11	177	136	0	0	13	17
New Jersey	1	2	28	38	0	0	3	4
Pennsylvania	1	3	182	107	0	0	62	22
East North Central States:								
Ohio	1	4	74	67	0	0	7	10
Indiana	0	2	13	26	0	0	8	10
Illinois	2	4	166	102	1	0	18	45
Michigan	0	2	82	123	0	0	15	4
Wisconsin	1	0	83	63	10	6	6	2
West North Central States:								
Minnesota	0	0	43	27	4	0	23	0
Iowa	0	0	19	19	6	2	2	1
Missouri [3]	2	0	13	21	0	0	25	63
North Dakota	0	0	15	5	0	0	1	1
South Dakota	0	0	4	----	3	0	0	1
Nebraska	0	0	10	1	3	2	0	0
Kansas	0	1	17	11	7	1	13	10
South Atlantic States:								
Delaware	1	0	2	----	0	0	3	5
Maryland [3] [4]	0	0	17	12	0	0	18	11
District of Columbia [4]	1	2	3	4	0	0	1	0
Virginia	72	1	17	18	0	0	46	38
West Virginia	0	1	11	21	0	0	16	23
North Carolina [3]	48	1	19	10	1	0	37	24
South Carolina [3]	1	0	2	2	0	0	26	58
Georgia [3]	1	0	1	2	0	0	61	77
Florid [3]	0	0	3	----	0	0	3	3

See footnotes at end of table.

Cases of certain communicable diseases reported by telegraph by State health officers for weeks ended July 20, 1935, and July 21, 1934—Continued

Division and State	Poliomyelitis		Scarlet fever		Smallpox		Typhoid fever	
	Week ended July 20, 1935	Week ended July 21, 1934	Week ended July 20, 1935	Week ended July 21, 1934	Week ended July 20, 1935	Week ended July 21, 1934	Week ended July 20, 1935	Week ended July 21, 1934
East South Central States:								
Kentucky	5	1	12	12	0	0	39	41
Tennessee	3	0	11	18	0	1	38	82
Alabama [3]	3	1	15	6	0	0	16	57
Mississippi [3]	0	1	12	12	0	0	17	21
West South Central States:								
Arkansas	1	0	4	1	5	0	34	16
Louisiana [3]	7	0	4	6	0	0	24	31
Oklahoma [5]	0	0	4	6	0	0	27	63
Texas [3]	1	11	17	40	0	15	32	105
Mountain States:								
Montana [4]	0	3	4	3	8	0	1	2
Idaho	0	1	1	2	0	0	0	1
Wyoming [4]	0	0	11	2	10	0	1	0
Colorado	0	1	29	8	0	0	4	3
New Mexico	0	0	6	3	0	0	6	9
Arizona	0	4	4	----	0	0	2	5
Utah [3]	0	0	34	1	0	0	2	1
Pacific States:								
Washington	0	12	11	10	23	5	3	6
Oregon [4]	1	1	27	19	1	0	3	7
California	35	154	73	81	3	0	7	9
Total	227	229	1,357	1,131	85	32	672	898
First 29 weeks of year	1,599	2,923	176,437	144,382	5,166	3,642	6,296	7,324

[1] New York City only.
[2] Typhus fever, week ended July 20, 1935, 49 cases, as follows: Missouri, 1; North Carolina, 1; South Carolina, 2; Georgia, 20; Florida, 1; Alabama, 14; Louisiana, 1; Texas, 9.
[3] Week ended earlier than Saturday.
[4] Rocky Mountain spotted fever, week ended July 20, 1935, 18 cases, as follows: Maryland, 3; District of Columbia, 1; Montana, 6; Wyoming, 7; Oregon, 1.
[5] Exclusive of Oklahoma City and Tulsa.

SUMMARY OF MONTHLY REPORTS FROM STATES

The following summary of cases reported monthly by States is published weekly and covers only those States from which reports are received during the current week.

State	Meningococcus meningitis	Diphtheria	Influenza	Malaria	Measles	Pellagra	Poliomyelitis	Scarlet fever	Smallpox	Typhoid fever
June 1935										
Arkansas	----	24	73	356	110	111	----	9	3	83
Georgia	9	31	64	484	39	99	2	24	13	153
Idaho	3	----	4	----	18	----	1	18	----	5
Illinois	38	197	79	9	4,500	----	6	3,182	8	44
Iowa	7	30	7	2	479	----	0	232	30	3
Kansas	6	22	39	4	934	----	3	113	74	13
Louisiana	3	45	35	196	145	20	16	25	6	71
Maryland	3	18	9	1	378	----	1	190	0	17
Massachusetts	2	36	----	2	1,486	1	6	742	0	6
Michigan	9	32	4	3	8,648	----	3	703	0	25
Minnesota	8	31	7	----	812	----	4	656	26	68
New Mexico	2	5	9	6	34	----	1	28	2	14
North Carolina	13	36	3	----	157	133	198	58	6	87
Ohio	34	83	74	6	5,277	----	5	1,171	4	56
Oregon	10	10	68	1	620	----	1	83	19	7
Pennsylvania	32	137	----	1	6,714	----	5	1,539	0	40
Rhode Island	2	3	----	----	1,739	----	0	40	0	3
South Carolina	----	68	322	1,061	60	318	5	4	0	145
Texas	10	126	237	2,000	232	57	8	158	47	112
West Virginia	9	45	62	----	547	----	1	124	0	30

June 1935

	Cases
Actinomycosis:	
Minnesota	1
Anthrax:	
Pennsylvania	1
Texas	3
Chicken pox:	
Arkansas	36
Georgia	46
Illinois	1,023
Iowa	176
Kansas	89
Louisiana	7
Maryland	350
Massachusetts	1,051
Michigan	729
Minnesota	254
New Mexico	69
North Carolina	190
Ohio	1,180
Oregon	156
Pennsylvania	2,315
Rhode Island	85
South Carolina	85
Texas	252
West Virginia	57
Dengue:	
Georgia	42
North Carolina	1
South Carolina	2
Texas	9
Diarrhea:	
Maryland	31
South Carolina	1,278
Diarrhea and enteritis:	
Ohio (under 2 years)	7
Dysentery:	
Georgia (amoebic)	22
Georgia (bacillary)	76
Illinois (amoebic)	11
Illinois (amoebic carriers)	21
Illinois (bacillary)	1
Louisiana (amoebic)	14
Louisiana (bacillary)	1
Maryland (bacillary)	20
Massachusetts (bacillary)	1
Michigan (amoebic)	5
Minnesota (bacillary)	1
New Mexico (amoebic)	1
New Mexico (bacillary)	1
North Carolina (bacillary)	4
Oregon (amoebic)	1
Pennsylvania (amoebic)	1
Texas (bacillary)	97
Epidemic encephalitis:	
Georgia	2
Illinois	8
Iowa	1
Kansas	2
Louisiana	2
Maryland	1
Michigan	2
Minnesota	5
New Mexico	1
Ohio	2
Pennsylvania	7
South Carolina	2
Texas	2
Food poisoning:	
Ohio	21
German measles:	
Illinois	2,306
Iowa	244
Kansas	116
Maryland	453
Massachusetts	5,898
Michigan	445
New Mexico	38
North Carolina	27
Ohio	1,148
Pennsylvania	4,104
Rhode Island	2
Hookworm disease:	
Georgia	294
Louisiana	12
South Carolina	97
Impetigo contagiosa:	
Kansas	1
Maryland	9
Oregon	5
Lead poisoning:	
Michigan	15
Ohio	9
Pennsylvania	1
Leprosy:	
Louisiana	1
Mumps:	
Arkansas	46
Georgia	141
Idaho	8
Illinois	475
Iowa	462
Kansas	291
Louisiana	2
Maryland	105
Massachusetts	406
Michigan	470
New Mexico	47
Ohio	1,048
Oregon	287
Pennsylvania	1,869
Rhode Island	89
South Carolina	189
Texas	301
West Virginia	10
Ophthalmia neonatorum:	
Illinois	5
Maryland	2
Massachusetts	152
Minnesota	2
Ohio	90
Pennsylvania	4
South Carolina	7
Paratyphoid fever:[1]	
Georgia	2
Illinois	3
Kansas	2
Louisiana	1
Massachusetts	1
Michigan	1
Ohio	1
South Carolina	6
Texas	7
Puerperal septicemia:	
New Mexico	6
Ohio	5
Rabies in animals:	
Illinois	32
Kansas	5
Louisiana	12
Maryland	1
Massachusetts	21
Michigan	9
Oregon	1
Rhode Island	1
South Carolina	47
Rabies in man:	
Georgia	1
Illinois	1
Rocky Mountain spotted fever:	
Illinois	1
Iowa	1
Maryland	7
North Carolina	3
Oregon	9
Scabies:	
Maryland	1
Oregon	5
Screw worm infection:	
Georgia	1
Septic sore throat:	
Georgia	25
Illinois	2
Kansas	5
Louisiana	4
Maryland	13
Massachusetts	16
Septic sore throat—Con.	
Michigan	13
New Mexico	1
North Carolina	3
Ohio	216
Oregon	4
Rhode Island	2
Tetanus:	
Georgia	5
Illinois	3
Kansas	1
Louisiana	4
Maryland	3
Massachusetts	1
Michigan	2
Ohio	1
South Carolina	2
Trachoma:	
Arkansas	3
Illinois	24
Massachusetts	2
Michigan	6
Minnesota	2
Ohio	1
Oregon	1
Pennsylvania	1
Trichinosis:	
Massachusetts	1
Michigan	2
Oregon	2
Tularaemia:	
Arkansas	5
Georgia	7
Illinois	1
Louisiana	2
Minnesota	3
Texas	5
Typhus fever:	
Georgia	37
Louisiana	1
North Carolina	2
South Carolina	2
Texas	21
Undulant fever:	
Georgia	9
Illinois	12
Iowa	9
Kansas	10
Louisiana	8
Maryland	4
Massachusetts	3
Michigan	7
Minnesota	11
New Mexico	1
North Carolina	2
Ohio	11
Oregon	1
Pennsylvania	5
Rhode Island	2
Texas	7
Vincent's infection:	
Illinois	12
Kansas	2
Maryland	13
Michigan	13
Oregon	4
Whooping cough:	
Arkansas	85
Georgia	172
Idaho	6
Illinois	907
Iowa	82
Kansas	309
Louisiana	18
Maryland	104
Massachusetts	361
Michigan	1,019
Minnesota	115
New Mexico	68
North Carolina	1,179
Ohio	486
Oregon	54
Pennsylvania	1,217
Rhode Island	41
South Carolina	234
Texas	374
West Virginia	121

PLAGUE-INFECTED GROUND SQUIRRELS IN LASSEN COUNTY, CALIF., AND WALLOWA COUNTY, OREG.

The Director of Public Health of California has reported that plague infection has been proved in a ground squirrel received at the laboratory on June 22, 1935, from a ranch in Lassen County, Calif., about 15 miles east and 11 miles south of Adin.

Plague infection was proved on June 17 and July 18, 1935, in 2 ground squirrels (*Citellus oregonus* and *Citellus columbianus*). These squirrels were found dead at points in Wallowa County, Oreg., approximately 5 and 6 miles north of Wallowa.

WEEKLY REPORTS FROM CITIES

City reports for week ended July 13, 1935

This table summarizes the reports received regularly from a selected list of 125 cities for the purpose of showing a cross section of the current urban incidence of the communicable diseases listed in the table. Weekly reports are received from about 700 cities, from which the data are tabulated and filed for reference.

State and city	Diphtheria cases	Influenza		Measles cases	Pneumonia deaths	Scarlet fever cases	Smallpox cases	Tuberculosis deaths	Typhoid fever cases	Whooping cough cases	Deaths, all causes
		Cases	Deaths								
Maine:											
Portland	0	------	0	2	0	0	0	0	1	2	21
New Hampshire:											
Concord	0	------	0	0	0	1	0	0	0	0	11
Manchester	0	------	0	0	0	0	0	1	0	0	13
Nashua	0	------	--------	0	-------	0	0	-------	0	0	--------
Vermont:											
Barre	0	------	0	0	0	0	0	0	0	0	--------
Burlington	0	------	0	0	0	0	0	0	0	1	15
Rutland	0	------	0	2	1	0	0	0	0	0	5
Massachusetts:											
Boston	5	------	1	33	15	22	0	5	0	6	202
Fall River	0	------	0	0	0	3	0	1	1	0	22
Springfield	0	------	0	11	0	2	0	2	2	0	30
Worcester	0	------	0	22	2	8	0	2	0	2	45
Rhode Island:											
Pawtucket	0	------	0	0	0	0	0	0	0	0	13
Providence	2	------	0	92	2	5	0	1	0	18	50
Connecticut:											
Bridgeport	2	------	0	17	0	5	0	1	0	1	21
Hartford	0	------	0	3	1	0	0	3	0	5	38
New Haven	0	1	0	3	1	1	0	0	1	4	35
New York:											
Buffalo	0	------	1	12	5	13	0	7	0	34	100
New York	25	3	1	599	78	76	0	76	7	142	1,299
Rochester	0	------	0	11	4	1	0	1	0	11	69
Syracuse	0	------	0	219	1	7	0	0	0	22	48
New Jersey:											
Camden	0	1	1	0	0	4	0	0	0	4	37
Newark	0	------	0	60	4	6	0	5	0	55	100
Trenton	0	------	0	5	1	1	0	0	0	0	35
Pennsylvania:											
Philadelphia	5	------	0	30	16	21	0	30	9	43	471
Pittsburgh	2	2	2	25	13	16	0	3	1	21	116
Reading	0	------	0	14	0	0	0	2	0	3	20
Scranton	0	------	0	0	-------	2	0	-------	0	0	--------
Ohio:											
Cincinnati	2	------	0	1	9	1	0	12	0	3	130
Cleveland	2	------	0	172	8	8	0	15	2	54	192
Columbus	0	------	0	6	3	7	0	7	1	3	69
Toledo	0	------	0	18	1	0	0	3	0	8	74
Indiana:											
Anderson	0	------	0	0	0	0	0	0	0	0	6
Fort Wayne	0	------	0	0	0	0	0	1	0	0	15
Indianapolis	3	------	0	8	4	6	0	6	0	18	--------
South Bend	0	------	0	1	0	1	0	0	0	2	19
Terre Haute	0	------	0	2	0	0	0	0	0	0	25

City reports for week ended July 13, 1935—Continued

State and city	Diphtheria cases	Influenza		Measles cases	Pneumonia deaths	Scarlet fever cases	Smallpox cases	Tuberculosis deaths	Typhoid fever cases	Whooping cough cases	Deaths, all causes
		Cases	Deaths								
Illinois:											
Alton	2	------	0	0	1	0	0	0	0	1	9
Chicago	10	4	1	202	42	89	0	41	3	118	648
Elgin	0	------	0	0	0	2	0	0	0	8	9
Moline	0	------	0	0	0	0	0	0	0	2	11
Springfield	0	------	0	0	0	2	0	0	1	4	21
Michigan:											
Detroit	0	------	0	100	11	16	0	17	2	191	238
Flint	1	------	0	2	3	3	0	2	0	5	28
Grand Rapids	0	------	0	15	0	4	0	0	0	23	25
Wisconsin:											
Kenosha	0	------	0	3	0	0	1	0	0	5	6
Milwaukee	0	1	1	256	6	21	0	6	0	47	91
Racine	0	------	0	43	0	9	0	0	0	18	12
Superior	0	------	0	1	0	0	0	0	0	1	8
Minnesota:											
Duluth	0	------	0	8	0	4	0	1	6	5	27
Minneapolis	1	------	0	10	5	18	0	3	37	3	111
St. Paul	0	------	0	14	3	6	2	6	0	4	61
Iowa:											
Cedar Rapids	0	------	0	1	------	0	0	------	0	8	------
Davenport	0	------	------	0	------	0	0	------	0	0	------
Des Moines	1	------	0	0	0	1	0	0	0	1	24
Sioux City	0	------	------	2	------	0	3	------	0	6	------
Waterloo	1	------	------	0	------	3	0	------	0	3	------
Missouri:											
Kansas City	5	------	0	1	4	5	0	4	0	1	99
St. Joseph	0	------	0	0	4	0	0	0	0	0	34
St. Louis	6	------	0	3	2	2	0	5	4	7	204
North Dakota:											
Fargo	0	------	0	0	2	2	0	0	0	2	7
Grand Forks	0	------	------	1	------	0	0	------	0	0	------
Minot	0	------	0	2	0	1	0	0	0	0	3
South Dakota:											
Aberdeen	0	------	------	7	------	0	0	------	0	0	------
Nebraska:											
Omaha	1	------	0	5	3	1	0	2	0	0	53
Kansas:											
Lawrence	0	------	0	4	0	0	0	0	0	0	4
Topeka	0	------	0	5	2	1	0	0	0	14	18
Wichita	1	------	0	2	1	0	0	1	0	4	28
Delaware:											
Wilmington	2	------	0	0	2	0	0	1	0	0	10
Maryland:											
Baltimore	3	------	0	3	13	16	0	15	1	25	203
Cumberland	0	------	0	1	1	0	0	0	1	0	8
Frederick	0	------	0	0	0	0	0	0	0	0	4
District of Columbia:											
Washington	15	------	0	10	4	7	0	14	1	12	148
Virginia:											
Lynchburg	0	------	0	0	0	0	0	1	1	57	9
Norfolk	0	------	0	0	3	0	0	2	3	1	31
Richmond	0	------	0	4	2	1	0	4	1	0	44
Roanoke	0	------	0	2	0	0	0	1	0	0	14
West Virginia:											
Charleston	1	------	0	0	0	0	0	0	0	0	6
Huntington	0	------	------	0	------	0	0	------	0	0	------
Wheeling	0	------	0	6	0	4	0	0	2	2	26
North Carolina:											
Gastonia	0	------	0	0	0	0	0	0	0	1	2
Raleigh	------	------	------	------	------	------	------	------	------	------	------
Wilmington	0	------	0	0	1	0	0	0	0	0	13
Winston-Salem	0	------	0	0	0	0	0	0	0	2	16
South Carolina:											
Charleston	0	1	1	0	0	0	0	1	3	0	11
Columbia	0	------	0	0	0	0	0	0	0	0	6
Florence	0	------	0	0	0	0	0	0	0	1	6
Greenville	0	------	0	0	2	1	0	0	0	0	13
Georgia:											
Atlanta	6	------	0	2	6	0	0	7	0	16	88
Brunswick	0	------	0	0	0	0	0	0	0	0	7
Savannah	0	------	0	0	0	0	0	4	0	1	32
Florida:											
Miami	1	------	0	2	1	0	0	1	2	2	23
Tampa	2	------	0	0	0	1	0	1	1	1	22

City reports for week ended July 13, 1935—Continued

State and city	Diphtheria cases	Influenza		Measles cases	Pneumonia deaths	Scarlet fever cases	Smallpox cases	Tuberculosis deaths	Typhoid fever cases	Whooping cough cases	Deaths, all causes
		Cases	Deaths								
Kentucky:											
Ashland											
Covington	0		0	0	0	1	0	2	0	0	13
Lexington	0		0	1	0	2	0	0	0	0	18
Louisville	0	1	0	4	3	8	0	2	1	4	63
Tennessee:											
Knoxville	0		0	0	0	0	0	0	2	0	20
Memphis	2		0	0	7	1	0	5	0	19	116
Nashville	0		0	0	4	2	0	4	1	7	56
Alabama:											
Birmingham	1		0	1	0	0	0	2	1	2	53
Mobile	0		0	0	0	1	0	1	0	0	16
Montgomery	2			0		0	0		2	0	
Arkansas:											
Fort Smith											
Little Rock	0		0	0	4	1	0	2	0	0	8
Louisiana:											
Lake Charles	0		0	0	0	0	0	0	0	1	3
New Orleans	14	1	0	2	10	0	0	12	1	2	155
Shreveport	1		0	0	6	0	0	1	4	0	52
Oklahoma:											
Oklahoma City	0	5	0	0	4	0	0	1	1	0	42
Tulsa	0			0		1	0		0	4	
Texas:											
Dallas	7		0	2	2	1	0	2	1	6	57
Fort Worth	0		0	0	5	0	0	3	0	0	51
Galveston	0		0	0	4	0	0	0	0	0	24
Houston	4		0	2	6	2	0	5	2	0	81
San Antonio											
Montana:											
Billings	1		0	3	0	0	0	0	0	0	15
Great Falls	0		0	0	1	0	0	0	0	2	4
Helena	0		0	1	0	0	0	0	0	7	2
Missoula	5		0	0	1	0	0	0	0	0	11
Idaho:											
Boise	0		0	0	0	0	0	0	0	1	5
Colorado:											
Colorado Springs	0		0	0	1	4	0	3	0	0	9
Denver	3		0	14	3	12	0	5	0	2	69
Pueblo	0		0	1	0	4	0	2	1	2	9
New Mexico:											
Albuquerque	0		0	0	0	0	0	2	1	4	18
Utah:											
Salt Lake City	0		0	0	1	17	0	0	0	40	26
Nevada:											
Reno	0		0	0	1	1	0	0	0	0	3
Washington:											
Seattle	0		0	58	4	3	1	2	0	2	81
Spokane	0		0	2	2	5	0	0	0	3	29
Tacoma	0		0	0	3	5	9	1	0	1	26
Oregon:											
Portland	0		0	17	3	9	0	2	0	0	74
Salem	0			0		1	0		0	0	
California:											
Los Angeles	9	16	0	45	11	16	1	25	1	9	309
Sacramento	1		0	22	0	5	0	0	2	3	21
San Francisco	0		1	47	7	13	0	5	0	18	144

City reports for week ended July 13, 1935—Continued

State and city	Meningococcus meningitis		Poliomyelitis cases
	Cases	Deaths	
Maine:			
Portland	1	0	0
Vermont:			
Barre	1	0	0
Massachusetts:			
Fall River	1	0	0
Worcester	1	0	1
Rhode Island:			
Providence	1	0	0
New York:			
New York	6	4	13
Pennsylvania:			
Philadelphia	0	0	1
Pittsburgh	1	0	0
Ohio:			
Cincinnati	1	1	0
Columbus	3	2	0
Indiana:			
Indianapolis	1	0	0
Illinois:			
Chicago	7	4	1
Michigan:			
Detroit	1	0	0
Wisconsin:			
Milwaukee	1	0	0
Racine	0	0	1
Minnesota:			
Minneapolis	1	1	0
Iowa:			
Sioux City	1	1	0
Missouri:			
Kansas City	0	1	0
St. Louis	1	3	0
Maryland:			
Baltimore	4	2	0
District of Columbia:			
Washington	1	0	3
Virginia:			
Norfolk	2	0	2
Richmond	0	0	5
Roanoke	0	0	1
West Virginia:			
Wheeling	1	0	0
South Carolina:			
Florence	0	0	1
Greenville	0	1	0
Florida:			
Tampa	0	1	0
Kentucky:			
Louisville	0	0	1
Tennessee:			
Memphis	0	1	0
Alabama:			
Mobile	0	0	1
Arkansas:			
Little Rock	1	2	0
Louisiana:			
New Orleans	0	0	2
Colorado:			
Denver	2	0	0
Oregon:			
Portland	1	0	0
California:			
Los Angeles	2	1	8

Epidemic encephalitis.—Cases: New York, 3; Newark, 1; Pittsburgh, 1; Chicago, 1; St. Louis, 2; Wichita, 1, *Pellagra.*—Cases: Boston, 1; Toledo, 1; Lynchburg, 1; Atlanta, 1; Savannah, 1; Knoxville, 1; Memphis. 3; New Orleans, 2; Los Angeles, 6.
Typhus fever.—Cases: Charleston, S. C., 1; Atlanta, 1; Savannah, 2; Tampa 1.
Dengue.—Cases: Miami, 1.
Rabies in man.—Deaths: Birmingham, 1.

FOREIGN AND INSULAR

CANADA

Provinces—Communicable diseases—2 weeks ended June 29, 1935.—During the 2 weeks ended June 29, 1935, cases of certain communicable diseases were reported by the Department of Pensions and National Health of Canada, as follows:

Disease	Prince Edward Island	Nova Scotia	New Brunswick	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Total
Cerebrospinal meningitis				1	1					2
Chicken pox		4	1	168	593	83	59	11	127	1,046
Diphtheria		5	3	30	17	21	3	1	1	81
Dysentery				10					1	11
Erysipelas		1		8	8	2			2	21
Influenza	2		1		5	1			1	10
Measles		16	73	679	3,831	165	147	201	356	5,468
Mumps		43			234	225	23	6	21	552
Paratyphoid fever					1		1			2
Pneumonia	3	2			7		3		3	18
Poliomyelitis				1				1		2
Scarlet fever	2	47	4	261	217	37	12	6	39	625
Trachoma						1	7			8
Tuberculosis	2	12	19	117	94	33	81	2	35	395
Typhoid fever		4	1	21	6	1	3	2	9	47
Undulant fever					3					3
Whooping cough		13	3	64	205	66	107	9	52	519

IRISH FREE STATE

Vital statistics—First quarter 1935.—The following statistics for the Irish Free State for the quarter ended March 31, 1935, are taken from the Quarterly Return of Marriages, Births, and Deaths, issued by the Registrar General, and are provisional:

	Number	Rates per 1,000 population		Number	Rates per 1,000 population
Population	3,033,000		Deaths from—Continued		
Marriages	3,805	5.00	Diphtheria	116	
Births	14,417	19.00	Influenza	326	.43
Total deaths	11,381	15.00	Measles	114	
Deaths under 1 year of age	1,125	(1)	Puerperal sepsis	17	[2] 1.18
Deaths from:			Scarlet fever	21	
Cancer	822	1.08	Tuberculosis (all forms)	959	1.26
Diarrhea and enteritis (under 2 years of age)	109		Typhoid fever	11	
			Whooping cough	46	

[1] Deaths under 1 year per 1,000 births, 78.
[2] Per 1,000 births.

ITALY

Communicable diseases—4 weeks ended May 26, 1935.—During the 4 weeks ended May 26, 1935, cases of certain communicable diseases were reported in Italy, as follows:

Disease	Apr. 29–May 5		May 6–12		May 13–19		May 20–26	
	Cases	Communes affected	Cases	Communes affected	Cases	Communes affected	Cases	Communes affected
Anthrax	7	7	3	3	8	8	9	7
Cerebrospinal meningitis	22	20	15	13	18	16	11	9
Chicken pox	478	174	520	178	510	180	569	178
Diphtheria and croup	500	252	457	222	341	187	452	196
Dysentery	9	6	3	3	7	5	7	7
Hookworm disease	6	5	7	5	13	7	19	8
Lethargic encephalitis	2	2			2	2	1	1
Measles	2,426	431	2,704	462	2,746	431	2,870	448
Paratyphoid fever	23	18	31	29	29	28	39	28
Poliomyelitis	12	12	4	4	8	8	14	14
Puerperal fever	29	26	27	25	36	32	31	30
Scarlet fever	343	120	388	140	325	130	424	133
Typhoid fever	176	114	183	111	191	124	212	119
Undulant fever	101	67	81	52	117	69	104	60
Whooping cough	311	88	358	110	369	103	326	104

JAMAICA

Communicable diseases—4 weeks ended July 13, 1935.—During the 4 weeks ended July 13, 1935, cases of certain communicable diseases were reported in Kingston, Jamaica, and in the island outside of Kingston, as follows:

Disease	Kingston	Other localities	Disease	Kingston	Other localities
Cerebrospinal meningitis		3	Puerperal fever		1
Chicken pox	5	21	Scarlet fever		1
Dysentery	3	1	Tuberculosis	53	91
Erysipelas	1		Typhoid fever	20	83
Leprosy		2			

VIRGIN ISLANDS

Notifiable diseases—April–June 1935.—During the months of April, May, and June 1935, cases of certain notifiable diseases were reported in the Virgin Islands, as follows:

Disease	April	May	June	Disease	April	May	June
Chicken pox	1			Malaria			1
Filariasis	4	1	3	Pellagra	1	2	
Gonorrhea	6	3	5	Poliomyelitis		2	
Hookworm disease	1	1	2	Syphilis	8	12	3
Leprosy	1			Tuberculosis			1

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER

(NOTE.—A table giving current information of the world prevalence of quarantinable diseases appeared in the PUBLIC HEALTH REPORTS for July 26, 1935, pp. 967-983. A similar cumulative table will appear in the PUBLIC HEALTH REPORTS to be issued Aug. 30, 1935, and thereafter, at least for the time being, in the issue published on the last Friday of each month.)

Plague

Belgian Congo—Blukwa region—Ituri.—During the week ended July 13, 1935, 1 case of plague with 1 death was reported at Ituri, Blukwa region, Belgian Congo.

Iraq—Baghdad.—During the week ended June 29, 1935, 1 case of plague was reported at Baghdad, Iraq.

United States.—A report of plague-infected ground squirrels in California and Oregon appears on page 1009 of this issue of PUBLIC HEALTH REPORTS.

Smallpox

Alaska—Juneau.—According to information dated July 22, 1935, 7 cases of smallpox had been reported at Juneau, Alaska. Vaccination certificates are required of all travelers leaving.

Chile—Chuquicamata.—A report dated July 19, 1935, states that 1 case of smallpox has been reported at Chuquicamata, Chile, infection originating in Bolivia. Vaccination is being carried on.

Siam—Bangkok.—During the week ended July 6, 1935, 4 cases of smallpox with 2 deaths were reported at Bangkok, Siam.

Yellow Fever

Brazil—Minas Geraes State.—According to information dated July 22, 1935, yellow fever has been reported in Brazil, as follows: 1 case at Rio Verde, and 1 case at Araguary, both in Minas Geraes State.